footsteps
BEHAVIORAL HEALTH

General Information

Client name _______________________________DOB: ____________Age: ______Today's date: _____________

If under 16, please give mother's name ______________________ and father's name ______________________

Marital Status S M D W Other____

Current status: ■Student ■Employed ■Unemployed ■Homemaker ■Retired ■ Other: _______________

If student, are you Full Time or Part Time? FT PT Please give School attended________________________

If working, please give Occupation and Place of Employment ____

Emergency contact ____Relationship _________________

Emergency contact Phone Number _________________________ Alternative Phone Number ________________

If person filling out form is not client, check here: ☐ What is your relationship to client? _____________________

Address & Contact Information

Home Address____

____State______ Zip______________________

Home phone ____________________________________Okay to call? Y N Okay to leave message? Y N

Cell phone ________________________________ _____Okay to call? Y N Okay to leave message? Y N

Work phone ____________________________________ Okay to call? Y N Okay to leave message? Y N

Email *(used for scheduling issues and payment reminders)* ____

Any special instructions when calling, leaving messages or emailing? _____________________________________

____

Insurance Information (complete ONLY if you will be seeking insurance reimbursement for your sessions)

Insurance company (eg: MHN, Cal-Viva, Anthem Medi-Cal, etc): _______________________________________

Name of employer providing insurance (if any) ____

Policy number _____________________________________ Group number _______________________________

Your name ____ Your DOB __________________________________

Policy holder name _________________________________ Policy holder DOB ___________________________

Insurance company address (see back of card) ____

____State _______ Zip ________________

Insurance company phone ____________________________ Insurance company fax _______________________

Note: Footsteps Behavioral health works mostly on an out of network basis. Generally, you will be required to cover the full session fee and receive reimbursement from your insurance company. Please check with your insurer to understand if you have a deductible for out of network coverage. Footsteps Behavioral Health will complete and submit all the appropriate paperwork for you.

Would you like to receive copies of invoices for FSA or HSA purposes? Y N

PLEASE TURN SHEET OVER FOR IMPORTANT INFORMATION & SIGNATURES

FOOTSTEPS BEHAVIORAL HEALTH 755 N Peach Ave Suite C5 Clovis CA 93611 Phone: 559.825.1324 Email: areyes@footstepsbehavioral.org Web: www.footstepsbehavioral.org

footsteps
BEHAVIORAL HEALTH

Initials and Signatures

_______ I understand it is my responsibility to pay for the session at the time of service.

_______ I affirm that I have willingly sought treatment from Footsteps Behavioral Health for issues relating to the field of mental health. I recognize that such treatment may involve exploration of my personal and family experience and has the potential to be emotionally unsettling. I agree and consent to receive treatment from Footsteps Behavioral Health at this time. I understand that I have the right to terminate such treatment at any time.

_______ I acknowledge that I have received, read, signed and consent to abiding by the Client Rights and Responsibilities document.

_______ I acknowledge that I have read and consent to the Notice of Privacy Practices document, which explains in detail my rights to access my Personal Health Information and how, when and with whom that information may be shared.

________ I acknowledge that if Footsteps Behavioral Health mental health practitioner deems the treatment I require to be beyond his/her level of training or resources as a practitioner that it is the practitioners ethical duty to provide referrals to other professionals or agencies. In the event that such referrals are, in her professional opinion, necessary for treatment to be effective, I recognize that in order to continue in therapy with Footsteps Behavioral health practitioner I will need to follow up on such referrals and/or obtain additional licensed clinical responsibility for my care. Such situations may include (but are not limited to): recurrent suicidality, alcohol or chemical dependency, eating disorders, domestic violence, symptoms of bipolar, psychosis or a personality disorder.

________ I agree that Footsteps Behavioral health mental health practitioners sole responsibility is in working with me as a therapist and that I will not enlist her in any legal proceedings related to my case. I further agree that neither her records nor her testimony will be subpoenaed for deposition or court testimony, and she will be exempt from conversations with social service personnel, parenting consultants, attorneys and members of the justice system.

Client Name (please print legibly) ____

Client Signature ____ Date ________________

FOOTSTEPS BEHAVIORAL HEALTH 755 N Peach Ave Suite C5 Clovis CA 93611 Phone: 559.825.1324 Email: areyes@footstepsbehavioral.org Web: www.footstepsbehavioral.org